

Army NAF Retiree Group Life Insurance Beneficiary Change Form

Retiree Name: _____
Retiree SSN: _____
Retiree address: _____

Retiree Telephone Number: _____

I wish to name the person(s) below as beneficiary(ies) of my Army NAF Group Life Insurance policy.

Primary Beneficiary:

1. Name: _____ Date of Birth: _____
SSN: _____ Relationship: _____ (ie: sibling, spouse, friend)
Address: _____
Phone Number: _____ Percentage of Benefit _____ %
2. Name: _____ Date of Birth: _____
SSN: _____ Relationship: _____ (ie: sibling, spouse, friend)
Address: _____
Phone Number: _____ Percentage of Benefit _____ %
3. Name: _____ Date of Birth: _____
SSN: _____ Relationship: _____ (ie: sibling, spouse, friend)
Address: _____
Phone Number: _____ Percentage of Benefit _____ %

In the event that none of your primary beneficiaries are living at the time of your death, please name a secondary beneficiary(ies)

Secondary Beneficiary:

1. Name: _____ Date of Birth: _____
SSN: _____ Relationship: _____ (ie: sibling, spouse, friend)
Address: _____
Phone Number: _____ Percentage of Benefit _____ %
2. Name: _____ Date of Birth: _____
SSN: _____ Relationship: _____ (ie: sibling, spouse, friend)
Address: _____
Phone Number: _____ Percentage of Benefit _____ %
3. Name: _____ Date of Birth: _____
SSN: _____ Relationship: _____ (ie: sibling, spouse, friend)
Address: _____
Phone Number: _____ Percentage of Benefit _____ %

Print Retiree Name: _____ SSN: _____

Signature of Retiree: _____ Date: _____

In order to honor this beneficiary designation, it must be signed and dated by the retiree
Please return form to:

Army NAF Employee Benefits Office, PO Box 100057, Arlington, VA 22210-3057